2019 Implementation Strategy Report

Kaiser Foundation Hospitals: Sunnyside and Westside

License number: #1073 and #14-1472

Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

March 18, 2020

KAISER PERMANENTE®

Kaiser Permanente Northwest Region Community Health

IS Report for KFH Sunnyside and KFH Westside

Contents

I. General information

Contact Person:	Dan Field, Executive Director, Community Health and External Affairs
Date of written plan:	October 31, 2019
Date written plan was adopted by authorized governing body:	March 18, 2020
Date written plan was required to be adopted:	May 15, 2020
Authorized governing body that adopted the written plan:	Kaiser Foundation Hospitals Board of Directors' Community Health Committee
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	Yes ☒ No ☐
Date facility's prior written plan was adopted by organization's governing body:	March 16, 2017
Name and EIN of hospital organization operating hospital facility:	Kaiser Foundation Hospitals, 94-1105628
Address of hospital organization:	One Kaiser Plaza, Oakland, CA 94612

II. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of healthcare. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

III. About Kaiser Permanente Community Health

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grant making to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs

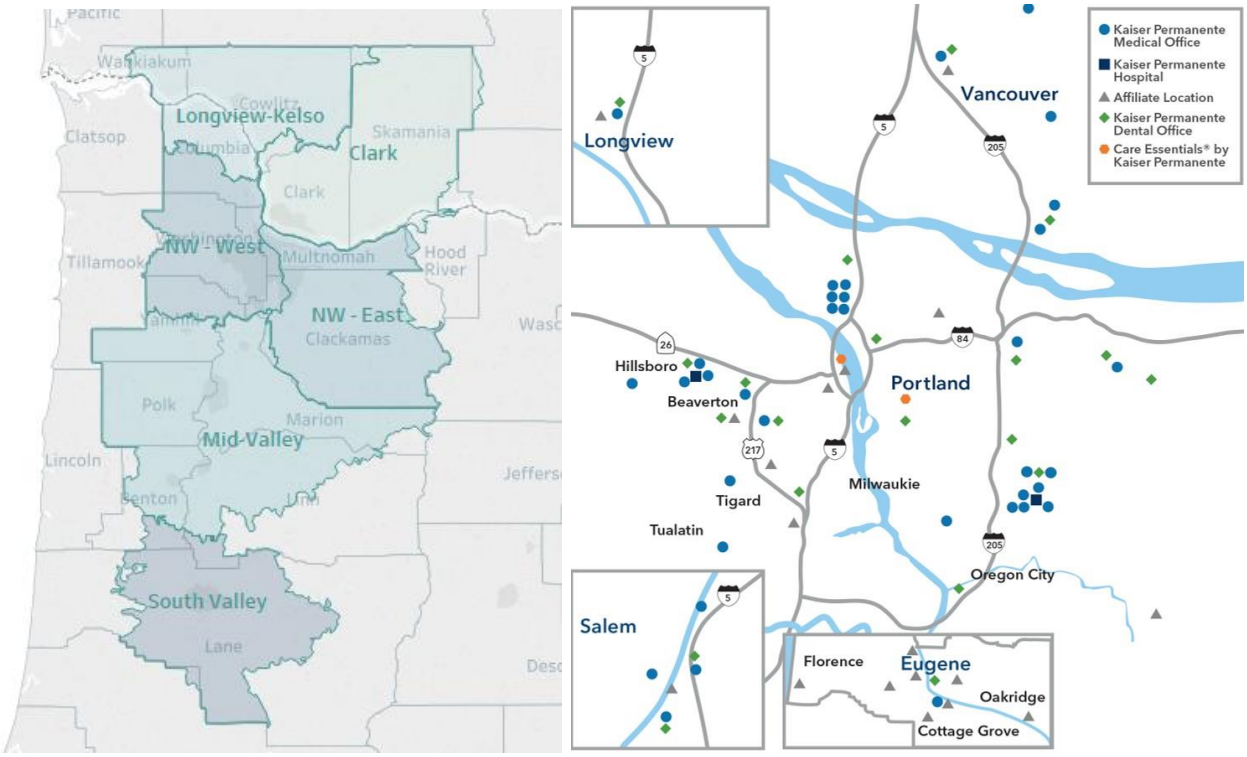
Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

IV. Kaiser Foundation Hospitals – Northwest Region

This Implementation Strategy serves as a joint report for the Northwest Region's two hospitals, KFH Sunnyside and KFH Westside. The hospitals define their community served by a shared service area and share the same centralized Community Health department. This structure promotes a single, comprehensive, region-wide approach to addressing community health needs. This report will use KPNW to collectively refer to the two hospitals, integrated health care delivery system, and a health plan.

A. Map of facility service area

Kaiser Permanente Northwest (KPNW) Service Areas



B. Geographic description of the community served (towns, counties, and/or zip codes)

The KPNW region includes 14 counties in six service areas across two states, listed from North to South:

- Longview-Kelso: Cowlitz, Wahkiakum and part of Columbia counties
- Clark service area: Clark and Skamania counties
- West: Washington, and parts of Columbia and Yamhill counties
- East: Multnomah and Clackamas counties
- Mid-Valley: Marion, Polk, Benton, Linn, and part of Yamhill counties
- South Valley: Lane County

The KPNW region includes two hospitals, KFH Sunnyside and KFH Westside, an integrated health care delivery system, and a health plan, and provides high-quality primary and specialty care and community benefit activities to a 14-county geography. KFH Sunnyside and KFH Westside hospitals primarily serve people living within the four county Portland metro area, which includes the Clark, West, and East service areas. KPNW also provides nonhospital services, has membership, and supports community health to the North in the Longview-Kelso service area, and to the South in the Mid-Valley and South Valley service areas.

The total population of the region is 3,386,009. About 75% of the region are white, 5% are Asian, 2% are Black/African American, 12% Hispanic, and less than 1% are Native American/Alaska Native. The East service area has the largest population (936,028), followed by West (857,049), and Mid-Valley (648,006). The East service area has the largest population of Black/African Americans (41,477, 4%), Native Americans (8,051, 1%), and Native Hawaiian/Pacific Islander (5,331, 1%). The West service area has the largest nonwhite (164,070, 19%), largest Asian (67,515, 8%), and multiple race (39,946, 5%) populations. Mid-Valley has the largest Hispanic population (119,680, 18%).

C. Demographic profile of community served

Race/ethnicity		**Socioeconomic data**	
Total Population	3,386,009	Living in poverty (<100% federal poverty level)	14.5%
Race		Children in poverty	18.2%
Asian	5.0%	Unemployment	3.8%
Black	2.3%	Adults with no high school diploma	9.4%
Native American/Alaska Native	0.9%		
Pacific Islander/Native Hawaiian	0.5%		
Some other race	3.4%		
Multiple races	4.7%		
White	83.3%		
Ethnicity			
Hispanic	12.3%		
Non-Hispanic	87.7%		

Source: American Community Survey, 2012-2016

V. Purpose of Implementation Strategy

This Implementation Strategy has been prepared in order to comply with federal tax law requirements set forth in Internal Revenue Code section 501(r) requiring hospital facilities owned and operated by an organization described in Code section 501(c)(3) to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community health needs identified through the community health needs assessment.

This Implementation Strategy is intended to satisfy each of the applicable requirements set forth in final regulations released in December 2014. This implementation strategy describes KPNW's planned response to the needs identified through the 2019 Community Health Needs Assessment

(CHNA) process. For information about KPNW's 2019 CHNA process and for a copy of the report please visit www.kp.org/chna.

List of Community Health Needs Identified in 2019 CHNA Report

The list below summarizes the health needs identified for the KPNW service area through the 2019 CHNA process.

High Priority Health Needs

1. Access to Care
2. Mental Health and Wellness
3. Economic Opportunity

Medium Priority Health Needs

4. Obesity, HEAL, Diabetes
5. Maternal and Infant Health
6. Substance Abuse

VI. Who was involved in the Implementation Strategy development

A. Partner organizations

KPNW developed this Implementation Strategy independently of other health systems. However, this report serves as a joint report for the Northwest Region's two hospitals, KFH Sunnyside and KFH Westside. KPNW contracted with two organizations to facilitate its strategic planning process, Insight for Action and the Oregon Health Equity Alliance (OHEA). Insight for Action led the strategic planning process, while OHEA led the community engagement process, conducted an equity audit, and applied an equity lens to the design and implementation of the strategic planning process.

B. Community engagement strategy

While not required by Federal CHNA regulations, Kaiser Permanente requires all KFH facilities developing Implementation Strategy plans to elicit community input throughout the plan development process. Community member and stakeholder engagement in the implementation strategy development process is intended to enable:

- KFH facilities to develop a deeper understanding of community perspective in developing Implementation Strategies, allowing opportunities for increased collaboration, potential impact, and sustainability
- Opportunities to engage community members beyond organizations and leaders with whom facilities may typically collaborate
- Transparency throughout the implementation strategy development process
- Opportunities to inform community leaders about Kaiser Permanente's unique structure and resources to effectively foster meaningful partnerships.

KPNW hired the Oregon Health Equity Alliance (OHEA) to facilitate sessions in which ten community partners made recommendations regarding KPNW community health strategies in four areas: place-based initiatives, mental health and wellness, the KPNW Health Career Scholarship Program, and the capacity-building initiative. In addition to facilitating community engagement and serving on the

strategic planning team, OHEA also provided guidance and recommendations around how to most equitably integrate community input into the strategic planning process.

After a short assessment, OHEA determined that given the conditions of this strategic planning process, the best opportunity for meaningful engagement would be through a few in depth sessions with community partners. Community partners were Black, Indigenous, and People of Color (BIPOC) who had:

1) experienced health inequities themselves,
2) experience working directly with communities most impacted by health inequities, and
3) experience working with large health institutions.

OHEA facilitated three meetings, each held one week apart. The first meeting provided participants an overview of the process, time for the group to get to know each other, and an in-depth summary of the four program areas. OHEA asked participants to review project materials and request any additional information they might need to provide meaningful input. In the time in between meetings, OHEA worked with KPNW staff to gather additional information requested by participants.

The second meeting was comprised of two work sessions. Participants worked in two program areas each. In these two work sessions, participants considered all the information presented and provided input and recommendations based on guiding questions asked by KPNW program leads. This was done in small group discussion format, with OHEA staff taking notes.

In the final meeting, the group revisited the first round of recommendations. In the first part of the meeting, participants edited and refined recommendations. In the latter half, KPNW program leads joined the space for a group discussion. Here participants presented recommendations and engaged KPNW staff in a dialogue.

After KPNW completed strategic planning, OHEA hosted a community report back dinner where KPNW staff shared with the community partners how their recommendations were integrated into strategic planning and transformed how KPNW approaches that work.

Community partners provided general feedback on the CHNA findings and targeted feedback on four program areas. For the Health Care Career Scholarship Program, they provided feedback on the current application, strategies for reaching underrepresented students and ensuring these students see themselves as potential applicants, and weighting of scoring criteria. Key recommendations included using current scholar recipients to engage potential applicants; allowing for community references, not just academic references; hosting culturally specific writing workshops, deemphasizing grammar mistakes; and increasing the award amount.

For the Capacity Building Initiative, community partners provided ways to integrate community input into strategy development, new technical assistance offerings, and focus areas for the next cohort of grantees. Key recommendations included adding community members from the priority population to the grant review committee, extending outreach beyond existing partners, removing health care and public health jargon, and prioritizing organizations working with asylum seekers, people with

intersectional identities, Micronesian communities, and people of color with mental health or wellness issues.

For the Mental Health and Wellness Grant Initiative, community partners described the impact when someone suddenly dies in their communities, how their communities experience suicide, and what an upstream oriented grant initiative should look like. Key recommendations included the importance of gathering together to grieve, the impact of toxic stress and intergenerational trauma on wellbeing, reclaiming cultural and traditional practices, community organizing as part of healing, investing in culture as prevention, and letting communities define what mental health and wellness means to them.

For the Place-Based Work, community partners identified issues with how the work was framed, criteria for assessing organizational readiness, and what place-based work KPNW should prioritize. Key feedback included the difficulty of relating to the term place-based while being displaced, many communities not being defined by geography, ensuring elders and youth are involved, supporting transformation by ensuring funding is making it into communities, and whether the name could be changed to community-based work.

Through the community engagement process, KPNW staff learned that the scope and vision of our programs are headed in the right direction, but our language and framing frequently are not community focused. The process created stronger relationships, transparency and representation, and brought excitement about reaching a better outcome. It also reinforced that strategies should address multiple priority needs at once. In future community engagement efforts, KPNW will strive to maintain regular communication and report on practices, provide a visual timeline to help reduce confusion, and identify other opportunities to implement this model.

C. Consultant(s) used

KPNW contracted with two organizations to facilitate its strategic planning process: Insight for Action and the Oregon Health Equity Alliance (OHEA). Insight for Action led the strategic planning process, while OHEA led the community engagement process, conducted an equity audit, and applied an equity lens to the design and implementation of the strategic planning process.

Insight for Action partners with purpose-driven organizations to strengthen their social impact by serving as a learning partner. Since 2008, Insight for Action has collaborated with over 40 foundations, healthcare systems, and community-based organizations on a variety of projects. They serve as a learning partner and collaborator with their clients to achieve social change. Their work is customized to produce optimal results, being agile and pivoting when changes are needed. They facilitate meaningful meetings where team members inquire and dialogue about what is known, unknown and unknowable about the problems and solutions. They gather and synthesize information to answer questions about problems and offer potential solutions as concise, digestible briefs. They transform ideas, prose, and data into clear visuals. They support pathways for continuously reflecting upon what is working and not working and intentionally adapting strategies for greater impact. They teach as they work, equipping partners with tools they need to continue the work independently.

The Oregon Health Equity Alliance (OHEA) is a collective effort of regional and state partners who seek to make Oregon a more equitable place for all. OHEA seeks to enact smart policies to improve our regional and statewide health and wellbeing through public policy, legislation, and policies that govern our workplaces, schools, and communities. They build from an accomplished record of statewide policy wins in areas including cultural competency for health professionals, prenatal care for all women, data equity standards, and supporting a growing traditional health workforce.

OHEA is open to organizations who serve constituents facing health inequities in the Tri-County region of Clackamas, Washington, and Multnomah counties. They have established a diverse, dynamic, and effective coalition of 33 member organizations, and adopted a five-year Regional Health Equity Plan. Together they educate, organize, and advocate for community-driven solutions to improve community health and wellbeing. They believe every Oregonian should have an equal chance to achieve their full health potential.

VII. Health needs that KPNW plans to address

A. Process and criteria used

Required criteria:

Before beginning the Implementation Strategy health need prioritization process, KPNW chose a set of criteria to use in selecting the list of health needs. The criteria were:

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.
- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- **The community prioritizes the issue over other issues:** Community priority refers to the frequency with which the community expressed concern about a health issue during the CHNA data collection process.
- **Leveraging KPNW assets:** KP can make a meaningful contribution to addressing the need because of its relevant expertise, existing strategies, and/or unique business assets as an integrated health system and because of an organizational commitment to improving community health.
- **Community partnerships:** Over the years, KPNW has developed relationships with many community-based organizations responding to the needs of the community. This criterion considers the focus and expertise of both funded and non-funded partners.
- **Community momentum:** This criterion considers whether legislation to address this need was introduced at the state government or local government level in 2019.

Process

KPNW started the health need selection process with the CHNA prioritization results based on the criteria: severity, magnitude, disparities, and community prioritization. Then each health need was scored based on three additional criteria: ability to leverage KPNW assets, existing community partnerships, and community momentum. These scores were added to the existing prioritization

scores and reranked. The results further differentiated the top three high priority needs from the rest of the identified needs. Based on results, KPNW Community Health selected the top three high priority needs: Access to Care, Mental Health and Wellness, and Economic Security. For more details on the CHNA prioritization process, refer to the KPNW 2019 CHNA report at www.kp.org/chna.

During the selection process, KPNW Community Health expanded the definition of Access to Care to include dental care to better reflect KPNW's Access to Care programs, many of which already included medical dental integration, and to ensure KPNW leverages all its assets. Mental Health was retitled to Mental Health and Wellness to better reflect the community's definition of mental health. The definition was also expanded to include addiction services to more accurately describe how the work is organized internally. The team also discussed how economic security encompasses upstream approaches to address chronic disease by focusing on food security, the impacts of poverty and homelessness, and holistic approaches to community health.

B. Health needs that KPNW plans to address

Access to Care – Access to comprehensive, affordable, quality medical and dental care is an important factor in determining quality of life. When communities across our region speak about access to care, they note the need for support in navigating the system, multiple language options, providers with cultural awareness and humility, and culturally diverse providers. Barriers to accessing care include racism and discrimination; financial insecurity due to medical and medication costs; cultural, social, and geographic isolation; lack of affordable and reliable transportation options; and lack of insurance and affordable and local care options. Community Health Workers are an integral part of overcoming barriers to health care access because they are from the community, speak the language, and are culturally aware.

Mental Health and Wellness – Mental health and wellness affects all areas of life, including a person's physical well-being and ability to work, perform well in school, and participate fully in family and community activities. Communities across our region experience significant stress, often because of racism, discrimination, and exclusion due to their race/ethnicity, socio-economic status, LGBTQI identities, disability status, and citizenship status. They also describe the need for help easing depression and other mental health concerns. Culturally-specific community members often feel isolated from their support systems and express the desire for community spaces, support for maintaining cultural values, and establishing a sense of belonging. While access to affordable, local, quality mental health and addiction programs and services is critical, strategies also need to include programs and services that strengthen resilience and promote social and emotional wellness for everyone in the community.

Economic Security – Social and economic conditions, including income, education, food security, and safe and stable housing are strongly associated with a person's health. Community members struggle with financial insecurity due to unaffordable housing costs, rent hikes, evictions, and instability in emergency housing. Racism and discrimination greatly impact economic security. Transportation barriers are also a concern. Financial insecurity impedes communities' ability to eat healthy foods and be physically active. Communities would like walkable access to grocery stores, farmer's markets, and community events. Immigrants and refugees face additional financial

challenges, such as a lack of credit history to assist in financial endeavors, or the lack of transferrable job skills and education from their home countries. Community members in our region believe that investing in businesses — particularly family-oriented and culturally diverse businesses — would encourage economic growth and financial security for the entire community.

VIII. KPNW's Implementation Strategies

A. About Kaiser Permanente's Implementation Strategies

As part of the Kaiser Permanente integrated health system, KPNW has a long history of working internally with Kaiser Foundation Health Plan, the Northwest Permanente P.C. Medical Group, and other Kaiser Foundation Hospitals, as well as externally with multiple stakeholders to identify, develop, and implement strategies to address the health needs in the community. These strategies are developed so that they:

- Are available broadly to the public and serve low-income individuals
- Are informed by evidence
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems
- Address federal, state, or local public health priorities
- Leverage or enhance public health department activities
- Advance increased general knowledge through education or research that benefits the public
- Otherwise would *not* become the responsibility of government or another tax-exempt organization

KPNW is committed to enhancing its understanding about how best to develop and implement effective strategies to address community health needs and recognizes that good health outcomes cannot be achieved without joint planning and partnerships with community stakeholders and leaders. These relationships are necessary as KPNW strives to address social drivers in tandem with medical needs. As such, KPNW welcomes future opportunities to enhance its strategic plans by relying on and building upon the strong community partnerships it currently has in place.

KPNW will draw on a broad array of strategies and organizational resources to improve the health of vulnerable populations within our communities, such as grant making, leveraged assets, collaborations and partnerships, as well as several internal KFH programs. The goals, outcomes, strategies, and examples of resources planned are described below for each selected health need.

B. 2019 Implementation Strategies by selected health need

Access to Care

Long term goal	All community members have access to high-quality, culturally appropriate health care services in coordinated delivery systems.
Intermediate goal(s)	• More individuals and families experience access to high-quality, culturally-appropriate medical and dental care and coverage within Kaiser Permanente. • More communities benefit from integrated care that meets their social, non-medical needs as a result of increased coordination between community clinics, social service organizations, and healthcare systems. • More people are able to access to high-quality care in community clinics. • More young people from diverse and low-income backgrounds complete postsecondary education or training and begin healthcare careers.
Strategies	• **Medicaid** – Provide high-quality medical and dental care to Medicaid participants including aged, blind, disabled individuals, and foster children who would otherwise struggle to access care. • **Charitable Health Coverage** – Provide access to comprehensive medical and dental care to low-income individuals and families who do not have access to public or private health coverage. • **Medical Financial Assistance** – Provide financial assistance to low-income individuals who receive care at Kaiser Permanente facilities and Salem Hospital and can't afford their medical expenses or cost sharing. • **Community Access Programs** – Provide access to a primary care home, to dental care, and to specialty care via Project Access-type programs. • **Thrive Local** – Deploy Thrive Local at priority sites to connect low-income individuals and families to community and government resources, confirm that their needs have been addressed, and incorporate that information into ongoing care plans. • **School Based Health Centers (SBHCs)** – Support the development of new SBHCs in the KPNW region and increase the ability of existing SBHCs to provide high-quality, comprehensive health services to adolescents, including dental services. • **Employee Volunteerism** – Provide KPNW clinician expertise to provide needed primary, specialty, and dental care during community service at safety net clinics through MLK Days and other times throughout the year. • **Traditional Health Workers (THWs)** – Provide resources to support and learn from a robust infrastructure of THWs with a focus on supporting community/clinic integration, addressing health disparities, providing culturally appropriate care, developing payment models, and connecting individuals to needed health services. • **Community Supported Clinics** – Partner with other local health systems to provide funding and technical assistance to assist community-supported clinics in expanding

	access to care for more individuals and families and building sustainable organizational infrastructures through the Health Systems Access to Care Fund at the Oregon Community Foundation. • **Medical Education** – Provide health professional programming to students participating in health-related academic or technical training programs, train new physicians and dentists, and offer continuing medical education credits to existing community clinic providers. • **Health Care Career Scholars** – Provide scholarships to diverse and low-income high school graduates to pursue degrees in health care in order to create a more diverse workforce and increase economic mobility. • **Internships** – Provide opportunities for diverse and low-income students to gain experience and exposure in health care through internships, externships, shadowing, and residency programs.
Expected outcomes	• People experiencing inequities in KPNW communities receive the right care, at the right times, in the right settings. • People experiencing inequities who are served by safety net partners and KPNW are treated with dignity and their unique needs are met through culturally appropriate care. • People have more opportunities to receive care from people who understand their culture, identity, and/or personal history.

Mental Health and Wellness

Long term goal	All community members experience emotional health and wellbeing.
Intermediate goal(s)	• More individuals and families have access to high-quality integrated mental health, wellness, and physical health services. • Communities experience greater access to a diverse, effective and well-supported mental health and wellness workforce, including Traditional Health Workers. • More people experiencing mental health and addiction challenges have access to crisis services and long-term social supports, including housing. • More adults and children benefit from prevention and resiliency strategies through emotional wellness and trauma-informed services, including screening for early trauma and culturally appropriate interventions.
Strategies	• **School Based Health Centers** – Contract and build relationships with school-based health centers to provide mental health and wellness services. • **Recovery High School** – Support Harmony Academy to provide a safe, sober and supportive education for youth in recovery, where they can develop the skills and strengths needed for personal, academic, vocational and community success.

	• **Culturally Responsive Care** – Train existing KPNW workforce on culturally responsive care and approaches to mental health and wellness in diverse communities, and partner with culturally specific behavioral health providers to better meet the demand for culturally responsive care. • **Peer Strategy** - Develop strategy to integrate peers into mental health, addiction, and wellness systems and addiction services, including partnering with Peer-run organizations to provide support for peer workforce • **Housing for Health** – Support organizations that help individuals with behavioral health challenges to secure and maintain safe, stable housing by involving Traditional Health Workers and collaboration between housing, health care, and community-based organizations. • **Unity Center** – Support behavioral crisis hospital in Portland metro area, designed to provide more options for people experiencing a psychiatric emergency. • **Trauma Informed and Resilient School Environments** – Engage in school-based efforts, leveraging programs and training about mental health, trauma, and resiliency. • **Educational Theatre Program** – Through theatre, inspire people to make healthy choices and learn about and discuss issues related to stress, bullying, mental health, and resilience. • **Community Emotional Wellness**– Support community based, multicultural, and culturally specific organizations to address community emotional wellness issues in our community.
Expected outcomes	• Everybody in KPNW communities has a place to go to address their emotional wellness needs. • People experiencing inequities in KPNW communities experience increased access to health-promoting systems, environments, programs, community supports, and services related to mental health. • Providers and educators develop knowledge, skills, and attitudes that support mental health.

Economic Security

Long term goal	All community members benefit from increased economic opportunity through improved access to quality education, skilled employment, stable housing, and healthy food.
Intermediate goal(s)	• More people are able to meet their individual and community social needs because of improve system connections and policy changes. • More pre-school, elementary, and high school students from diverse and low-income communities are healthy and succeeding academically.

	• More individuals and families are able to access high-quality, affordable housing and supportive services. • More individuals and families are able to access high-quality, affordable, healthy food.
Strategies	• **Economic Opportunity** – Support long-term economic vitality of communities through procurement, hiring and workforce development, small business development, impact investing, and public policy. • **CityHealth** – Implement the CityHealth initiative to support the City of Portland and Multnomah County to adopt and implement evidence-based policies to advance health and well-being. • **Inner City Capital Connections** – Provide training, education, and mentorship to small businesses seeking to increase their capacity and access new sources of funding. • **Place Based Initiatives** – Collaborate with existing community networks and leverage KPNW assets to address the upstream social determinants of health through community and neighborhood transformation. • **Health and Education Fund** – Fund the exploration and implementation of interventions that address the nexus of health and education through a field of interest fund partnering with other foundations, community organizations, employers, health plans and the educational system. • **Reach Out and Read** – Leverage pediatric resources and support Kaiser Permanente organizational infrastructure to give young children a foundation for success by incorporating books into pediatric care and encouraging families to read aloud together. • **Early Education and Health** – Integrate health care professionals into existing school community site teams to help determine evidence-based approaches to improving health and education outcomes for young children. • **Thriving Schools** – Fund and advocate for the integration of physical activity before, during, and after school through organizations and partnerships. • **Attendance Initiative** – Fund community-based organizations and educational service districts to reduce individual, family, community, and systems barriers to school attendance. • **Education Coalition Building** – Collaborate with local educational coalitions who advocate to improve school environments and educational systems. • **Housing/Homelessness** – Support efforts to reduce homelessness and increase housing stability by strengthening systems and engaging in cross-sector partnerships to increase affordable housing supply, expand availability of housing supports, shape policy and catalyze innovations. • **Regional Supportive Housing Impact Fund (RSHIF)** – In partnership with other health systems, businesses and foundations, establish a flexible supportive housing fund in the Portland tri-county region, with a catalytic KP initiative to house 300 homeless people, age 50 and above, by the end of 2020.

	• **RxHome Fund** – Pursue social impact investment opportunities from Kaiser Permanente's national revolving loan fund to support affordable housing development in the Northwest. • **Built for Zero** – Provide Washington, Clackamas, Lane, and Marion/Polk counties with access to the Built for Zero program's technical assistance and tools to help end chronic and/or veteran homelessness. • **Supportive housing in Eugene** – Contribute capital and operational funding for The Commons on MLK, a 51-unit supportive housing development for individuals struggling with chronic homelessness in Eugene. • **Food for Life** – Deliver a multi-pronged approach to transform economic, social and policy environments to improve food security for the communities we serve. • **Employee Volunteerism** – Support community-based organizations and schools through community service during MLK Days and other times throughout year. • **Capacity Building Initiatives** – Support the development and increase the capacity of community based, multicultural, and culturally specific organizations to improve the health of their communities.
Expected outcomes	• People in KPNW communities experience improved economic and educational opportunities, improved family and social support, and other social and economic factors that influence health. • KPNW communities have more safe, affordable housing units and increased housing-related services and resources to meet the specific needs of a variety of housing insecure communities. • More students receive the support they need to be in class and ready to learn, and their academic performance and graduate rates improve. • KPNW and our partners advance a public policy agenda to create conditions that ensure the health of individuals experiencing inequities.

C. Our commitment to Community Health

At Kaiser Permanente, our scale and permanence in communities mean we have the resources and relationships to make a significant impact, and wherever possible, our regions and facilities collaborate with each other and with key institutions in our communities, such as schools, health departments, and city/county governments, to create greater impact. The CHNA/IS process also presents the opportunity to reinforce and scale national strategies to address health needs that impact all of our communities, even if those health needs are not prioritized locally. The following strategies illustrate the types of organizational business practices we implement to address health needs and contribute to community health and well-being:

- **Reduce our negative environmental impacts and contribute to health at every opportunity.** We have optimized the ways in which we manage our buildings; purchase food, medical supplies and equipment; serve our members; consume energy; and process waste. The following strategies illustrate several of our practices that enable us to operate effectively while creating a healthier environment for everyone. Our Environmentally Preferable

Purchasing Standard prioritizes the procurement of products with fewer chemicals of concern and less resource intensity, thus encouraging suppliers to increase the availability of healthier products. We are building renewable energy programs into our operations, with plans to be carbon neutral in 2020. We recognize that mitigating the impacts of climate change and pollution is a collective effort, and we are therefore proud to work with like-minded organizations and individuals, including the United Nations, Health Care Without Harm, government entities, as well as other influencers that advocate for environmental stewardship in the healthcare industry and beyond.

- **Deploy research expertise to conduct, publish, and disseminate epidemiological and health services research.** Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes in diverse populations disproportionately impacted by health disparities. Research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. They cover a wide range of topics including cardiovascular disease, cancer, diabetes, substance abuse, mental health, maternal and child health, women's health, health care delivery, health care disparities, pharmaco-epidemiology, and studies of the impact of changing health care policy and practice.
- **Implement healthy food policies to address obesity/overweight**, such as purchasing sustainable, locally produced fruits and vegetables; supporting local restaurants and caterers that meet KP's Healthy Picks and to make more available healthier food options in our communities; and supporting vendors that hire under/unemployed residents (with living wages and benefits) in the food production/distribution process. We also partner with school districts and city governments to support them in adopting and implementing healthy food procurement policies.
- **Contribute toward workforce development, supplier diversity, and affordable housing to address economic security.** We support supplier diversity by implementing policies and standards to procure supplies and services from a diverse set of providers; working with vendors to support sub-contracting with diverse suppliers; partnering with community-based workforce development programs to support a pipeline for diverse suppliers; and building the capacity of local small businesses through training on business fundamentals. We also seek to reduce homelessness and increase the supply of affordable housing by strengthening systems to end homelessness and shaping policies to preserve and stimulate the supply of affordable housing.

IX. Evaluation plans

Kaiser Permanente has a comprehensive measurement strategy for Community Health. Our vision at Kaiser Permanente is for our communities to be the healthiest in the nation. To that end, we are committed to pursuing a deep and rigorous understanding of the impact of our community health efforts. We monitor the health status of our communities and track the impact of our many initiatives on an ongoing basis. And we use our measurement and evaluation data, and information gathered through our CHNAs, to improve the effectiveness of our work and demonstrate our impact. The CHNAs can help inform our comprehensive community health strategy and can help highlight areas

where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

In addition, KPNW will monitor and evaluate the strategies listed above for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and metrics specific to KFH leveraged assets. In addition, KPNW tracks outcomes, including behavior and health outcomes, as appropriate and where available.

X. Health needs KPNW does not intend to address

Two medium priority health needs from the 2019 CHNA will not be the focus of this Implementation Strategy. These were not ranked as highly as the three high priority health needs in either the CHNA prioritization or selection processes. The needs that will not be addressed are:

- Obesity/HEAL/Diabetes
- Maternal and Infant Health

Substance Abuse was the third medium priority health need listed in the 2019 CHNA and has since been included in the approach to Mental Health and Wellness. Additionally, by investing in strategies focused on the social determinants of health through economic security, we expect to see an improvement in indicators related to chronic disease.

While these health needs are not the focus of this Implementation Strategy, KPNW may consider investing resources in these areas as appropriate, depending on opportunities for KPNW to leverage its assets in partnership with local communities, and as they intersect with approaches to address the three priority health needs. This report does not encompass a complete inventory of everything KPNW does to support the health of our communities, including our commitment to environmental stewardship.